

# Breast & Cervical Health Check Annual Enrollment Form

Clinic Name:		Medical Record No:		Appointment:    -    -    :		
Last Name:			First Name:		MI:	
Address:			City/State/Zip:			
Soc Sec No:		Date of Birth:    -    -		Day Phone:		
Latina/Hispanic Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No				Night Phone:		
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Eskimo <input type="checkbox"/> Other Alaska Native (Check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Aleut <input type="checkbox"/> American Indian						
Most recent Pap test you had was: <input type="checkbox"/> less than 5 years ago <input type="checkbox"/> 5+ years ago <input type="checkbox"/> Never Most recent Mammogram you had was: <input type="checkbox"/> less than 5 years ago <input type="checkbox"/> 5+ years ago <input type="checkbox"/> Never Do you smoke or chew tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No    Please mail me information on quitting <input type="checkbox"/>						
Medical Coverage: <i>Check all that apply.</i> <input checked="" type="checkbox"/> <b>Medicare Part B – Not eligible for BCHC</b> <input type="checkbox"/> None <input type="checkbox"/> Medicaid    ID number: _____ <input type="checkbox"/> Insurance    Company name: _____ (on insurance card)						
<b>Household Income:</b> 1. <b>Circle the number of people living in your household.</b> The number in your household includes yourself, a spouse, relatives and all the children who live with you. 2. <b>Circle the household income (or range) on the same line where the household size is circled.</b> Household income includes all money from jobs, tips, alimony, child support, public assistance, disability, social security, unemployment, and Permanent Fund Dividends.						
<b>Monthly</b>	Household	Less Than	Between	Between	Between	More Than
	1	\$1,128	\$1,129 - \$1,691	\$1,692 - \$2,255	\$2,256 - \$2,819	\$2,819
	2	\$1,518	\$1,519 - \$2,276	\$2,277 - \$3,035	\$3,036 - \$3,794	\$3,794
	3	\$1,908	\$1,909 - \$2,861	\$2,862 - \$3,815	\$3,816 - \$4,769	\$4,769
	4	\$2,298	\$2,299 - \$3,446	\$3,447 - \$4,595	\$4,596 - \$5,744	\$5,744
	5	\$2,688	\$2,689 - \$4,031	\$4,032 - \$5,375	\$5,376 - \$6,719	\$6,719
	6	\$3,078	\$3,079 - \$4,616	\$4,617 - \$6,155	\$6,156 - \$7,694	\$7,694
	7	\$3,468	\$3,469 - \$5,201	\$5,202 - \$6,935	\$6,936 - \$8,669	\$8,669
<b>OR</b> Add \$975 for each additional person						
<b>Yearly</b>	Household	Less Than	Between	Between	Between	More Than
	1	\$13,530	\$13,531 - \$20,295	\$20,296 - \$27,060	\$27,061 - \$33,825	\$33,825
	2	\$18,210	\$18,211 - \$27,315	\$27,316 - \$36,420	\$36,421 - \$45,525	\$45,525
	3	\$22,890	\$22,891 - \$34,335	\$34,336 - \$45,780	\$45,781 - \$57,225	\$57,225
	4	\$27,570	\$27,571 - \$41,355	\$41,356 - \$55,140	\$55,141 - \$68,925	\$68,925
	5	\$32,250	\$32,251 - \$48,375	\$48,376 - \$64,500	\$64,501 - \$80,625	\$80,625
	6	\$36,930	\$36,931 - \$55,395	\$55,396 - \$73,860	\$73,861 - \$92,325	\$92,325
	7	\$41,610	\$41,611 - \$62,415	\$62,416 - \$83,220	\$83,221 - \$104,025	\$104,025
Add \$11,700 for each additional person						
<b>I want to enroll in BCHC. The information I provided here is correct.</b>						
Client Signature: _____ Date: _____						
If not completed by the woman named above, but recorded from information provided by her: Organization: _____ by _____ on _____ - _____ - _____						

**IF YELLOW SECTIONS ARE NOT COMPLETE WHEN THE FORM IS SUBMITTED PAYMENT FOR SERVICES WILL BE DELAYED.**  
**THIS FORM MUST BE SUBMITTED TO:** State of Alaska / BCHC, 4701 Business Park Blvd., Building J, Suite 20, Anchorage, AK 99503  
**FAX:** (907) 269-3414

Revised 06/10

**Breast & Cervical Health Check  
Client Information Handout**

If you are eligible and wish to enroll in Breast & Cervical Health Check (BCHC) here are some things you will need to know. BCHC is the State of Alaska's program that pays for breast and cervical cancer screening and many diagnostic services.

- BCHC does not cover the cost of all tests or services you may need. You may need to pay for the tests or services not covered by BCHC.
- Ask your provider whether you may have to pay for some services.
- If you have health insurance, your insurance will be billed before BCHC is billed.
- You may receive statements about the cost of your care.
- Read and keep track of all your statements. If you think there is an error or you have questions, call BCHC at 1-800-410-6266.
- BCHC refers women to Medicaid when treatment is needed. Referral to Medicaid does not guarantee coverage.
- BCHC treats all clinical and personal information as confidential.
- Your enrollment in BCHC is good for one year from the date you enroll.

I enrolled on \_\_\_\_\_ My BCHC clinic is \_\_\_\_\_

Please keep for your records

**Client**